		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043711

Facility Name: OAKWOOD HEALTH CARE CENTER

Address: 605 EAST CHURCH STREET, P.O. BOX KEWANEE (Number) (City) 61443 (Zip Code)

County: HENRY

Telephone Number: (309) 852-3389 **Fax #** (309) 853-1838

IDPA ID Number: 830320180018

Date of Initial License for Current Owners: 02/07/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William H. Keys **Telephone Number:** (317) 208-2740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Larry Bonds
(Title) President

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,000	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	32	3,180	3,212	8
9	SNF/PED	0	0	0		9
10	ICF	26,039	10,375	0	36,414	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	26,039	10,407	3,180	39,626	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.28%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/07/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/07/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 200 and days of care provided 3,180

Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	168,654	15,972	13,151	197,777		197,777		197,777			1
2	Food Purchase		207,263		207,263		207,263		207,263			2
3	Housekeeping	81,931	21,096		103,027		103,027		103,027			3
4	Laundry	79,473	21,633		101,106		101,106		101,106			4
5	Heat and Other Utilities			181,729	181,729		181,729	96	181,825			5
6	Maintenance	60,093	19,214	32,278	111,585		111,585	260	111,845			6
7	Other (specify):* Waste Removal			7,567	7,567		7,567		7,567			7
8	**TOTAL General Services**	390,151	285,178	234,725	910,054		910,054	356	910,410			8
	B. Health Care and Programs											
9	Medical Director	18,704			18,704		18,704		18,704			9
10	Nursing and Medical Records	1,162,314	88,225	28,813	1,279,352		1,279,352		1,279,352			10
10a	Therapy	8,424	55,893	306,874	371,191		371,191	11	371,202			10a
11	Activities	45,578	908	8,262	54,748		54,748		54,748			11
12	Social Services	51,718		3,217	54,935		54,935		54,935			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,286,738	145,026	347,166	1,778,930		1,778,930	11	1,778,941			16
	C. General Administration											
17	Administrative	76,164			76,164		76,164		76,164			17
18	Directors Fees											18
19	Professional Services			136,030	136,030		136,030	195,691	331,721			19
20	Dues, Fees, Subscriptions & Promotions			9,626	9,626		9,626	721	10,347			20
21	Clerical & General Office Expenses	119,313	75,401	326,992	521,706		521,706	68,640	590,346			21
22	Employee Benefits & Payroll Taxes			347,937	347,937		347,937	12	347,949			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,796	14,796		14,796	7,868	22,664			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			123,169	123,169		123,169	82,102	205,271			26
27	Other (specify):*											27
28	**TOTAL General Administration**	195,477	75,401	958,550	1,229,428		1,229,428	355,034	1,584,462			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,872,366	505,605	1,540,441	3,918,412		3,918,412	355,401	4,273,813			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER #0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			236,273	236,273		236,273		236,273			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			429,786	429,786		429,786	3,490	433,276			32
33	Real Estate Taxes			54,818	54,818		54,818	122	54,940			33
34	Rent-Facility & Grounds							3,991	3,991			34
35	Rent-Equipment & Vehicles			19,510	19,510		19,510	758	20,268			35
36	Other (specify):* See Attached			146,801	146,801		146,801	(98,657)	48,144			36
37	**TOTAL Ownership**			887,188	887,188		887,188	(90,296)	796,892			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			4,950	4,950		4,950		4,950			38
39	Ancillary Service Centers		54,064	6,805	60,869		60,869		60,869			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,100	137,100		137,100		137,100			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		54,064	148,855	202,919		202,919		202,919			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,872,366	559,669	2,576,484	5,008,519		5,008,519	265,105	5,273,624			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ #VALUE!	#####	$	1
2	Other Care for Outpatients	#VALUE!	#####		2
3	Governmental Sponsored Special Programs	#VALUE!	#####		3
4	Non-Patient Meals	#VALUE!	#####		4
5	Telephone, TV & Radio in Resident Rooms	#VALUE!	#####		5
6	Rented Facility Space	#VALUE!	#####		6
7	Sale of Supplies to Non-Patients	#VALUE!	#####		7
8	Laundry for Non-Patients	#VALUE!	#####		8
9	Non-Straightline Depreciation	#VALUE!	#####		9
10	Interest and Other Investment Income	#VALUE!	#####		10
11	Discounts, Allowances, Rebates & Refunds	#VALUE!	#####		11
12	Non-Working Officer's or Owner's Salary	#VALUE!	#####		12
13	Sales Tax	#VALUE!	#####		13
14	Non-Care Related Interest	#VALUE!	#####		14
15	Non-Care Related Owner's Transactions	#VALUE!	#####		15
16	Personal Expenses (Including Transportation)	#VALUE!	#####		16
17	Non-Care Related Fees	#VALUE!	#####		17
18	Fines and Penalties	#VALUE!	#####		18
19	Entertainment	#VALUE!	#####		19
20	Contributions	#VALUE!	#####		20
21	Owner or Key-Man Insurance	#VALUE!	#####		21
22	Special Legal Fees & Legal Retainers	#VALUE!	#####		22
23	Malpractice Insurance for Individuals	#VALUE!	#####		23
24	Bad Debt	#VALUE!	#####		24
25	Fund Raising, Advertising and Promotional	#VALUE!	#####		25
26	Income Taxes and Illinois Personal Property Replacement Tax	#VALUE!	#####		26
27	Nurse Aide Training for Non-Employees	#VALUE!	#####		27
28	Yellow Page Advertising	#VALUE!	#####		28
29	Other-Attach Schedule (See page 5a)	#VALUE!	#####		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ #VALUE!		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$ #VALUE!	######	31
32	Donated Goods-Attach Schedule*	#VALUE!	######	32
33	Amortization of Organization & Pre-Operating Expense	#VALUE!	######	33
34	Adjustments for Related Organization Costs (Schedule VII)	#VALUE!	######	34
35	Other- Attach Schedule	#VALUE!	######	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ #VALUE!		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ #VALUE!		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OAKWOOD HEALTH CARE CENTER

ID# 0043711

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	#VALUE!	$	#VALUE!	#VALUE!	1
2	#VALUE!		#VALUE!	#VALUE!	2
3	#VALUE!		#VALUE!	#VALUE!	3
4	#VALUE!		#VALUE!	#VALUE!	4
5	#VALUE!		#VALUE!	#VALUE!	5
6	#VALUE!		#VALUE!	#VALUE!	6
7	#VALUE!		#VALUE!	#VALUE!	7
8	#VALUE!		#VALUE!	#VALUE!	8
9	#VALUE!		#VALUE!	#VALUE!	9
10	#VALUE!		#VALUE!	#VALUE!	10
11	#VALUE!		#VALUE!	#VALUE!	11
12	#VALUE!		#VALUE!	#VALUE!	12
13	#VALUE!		#VALUE!	#VALUE!	13
14	#VALUE!		#VALUE!	#VALUE!	14
15	#VALUE!		#VALUE!	#VALUE!	15
16	#VALUE!		#VALUE!	#VALUE!	16
17	#VALUE!		#VALUE!	#VALUE!	17
18	#VALUE!		#VALUE!	#VALUE!	18
19	#VALUE!		#VALUE!	#VALUE!	19
20	#VALUE!		#VALUE!	#VALUE!	20
21	#VALUE!		#VALUE!	#VALUE!	21
22	#VALUE!		#VALUE!	#VALUE!	22
23	#VALUE!		#VALUE!	#VALUE!	23
24	#VALUE!		#VALUE!	#VALUE!	24
25	#VALUE!		#VALUE!	#VALUE!	25
26					26
27	#VALUE!		#VALUE!	#VALUE!	27
28	#VALUE!		#VALUE!	#VALUE!	28
29	#VALUE!		#VALUE!	#VALUE!	29
30	Other - Goodwill		(146,801)	36	30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39	Subtotal Line 29 (146,801)			#VALUE!	39
40				#VALUE!	40
41	#VALUE!		#VALUE!	#VALUE!	41
42	#VALUE!		#VALUE!	#VALUE!	42
43					43
44	#VALUE!		#VALUE!	#VALUE!	44
45					45
46	#VALUE!		#VALUE!	#VALUE!	46
47	#VALUE!		#VALUE!	#VALUE!	47
48					48
49	**Total**		#VALUE!		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER **#** 0043711 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	96	0	0	0	0	0	0	0	0	0	96	5
6	Maintenance	0	260	0	0	0	0	0	0	0	0	0	260	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	356	0	0	0	0	0	0	0	0	0	356	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	11	0	0	0	0	0	0	0	0	0	11	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	11	0	0	0	0	0	0	0	0	0	11	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	195,691	0	0	0	0	0	0	0	0	0	195,691	19
20	Fees, Subscriptions & Promotions	0	721	0	0	0	0	0	0	0	0	0	721	20
21	Clerical & General Office Expenses	0	68,640	0	0	0	0	0	0	0	0	0	68,640	21
22	Employee Benefits & Payroll Taxes	0	12	0	0	0	0	0	0	0	0	0	12	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,868	0	0	0	0	0	0	0	0	0	7,868	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	82,102	0	0	0	0	0	0	0	0	0	82,102	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	355,034	0	0	0	0	0	0	0	0	0	355,034	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	355,401	0	0	0	0	0	0	0	0	0	355,401	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	3,490	0	0	0	0	0	0	0	0	0	3,490	32
33	Real Estate Taxes	0	0	122	0	0	0	0	0	0	0	0	122	33
34	Rent-Facility & Grounds	0	0	3,991	0	0	0	0	0	0	0	0	3,991	34
35	Rent-Equipment & Vehicles	0	0	758	0	0	0	0	0	0	0	0	758	35
36	Other (specify):*	(146,801)	0	48,144	0	0	0	0	0	0	0	0	(98,657)	36
37	**TOTAL Ownership**	(146,801)	3,490	53,015	0	0	0	0	0	0	0	0	(90,296)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(146,801)	358,891	53,015	0	0	0	0	0	0	0	0	265,105	45

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Organizational Structure Description						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food Purchase	$	Senior Living Properties, LLC	100.00%	$ 0	$	1
2	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	96	96	2
3	V	6	Maintenance		Senior Living Properties, LLC	100.00%	260	260	3
4	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		4
5	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0		5
6	V	10a	Therapy		Senior Living Properties, LLC	100.00%	11	11	6
7	V	19	Professional Services		Senior Living Properties, LLC	100.00%	195,691	195,691	7
8	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	721	721	8
9	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	68,640	68,640	9
10	V	22	Employee Benefits & Payroll Taxes		Senior Living Properties, LLC	100.00%	12	12	10
11	V	24	Travel and Seminar		Senior Living Properties, LLC	100.00%	7,868	7,868	11
12	V	26	Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	82,102	82,102	12
13	V	32	Interest		Senior Living Properties, LLC	100.00%	3,490	3,490	13
14	Total			$			$ 358,891	$ * 358,891	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	33	Real Estate Taxes	$	Senior Living Properties, LLC	100.00%	$ 122	$ 122	15
16	V	34	Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	3,991	3,991	16
17	V	35	Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	758	758	17
18	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	48,144	48,144	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 53,015	$ * 53,015	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 12400 N. Meridian Street, Suite 180
City / State / Zip Code: Carmel, Indiana 46032
Phone Number: (317) 208-2740
Fax Number: (317) 575-2562

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	See attachment	See attachment	See attachment	$ 0	$	See attachme	$ 0	1
2	5	Heat and Other Utilities	See attachment	See attachment	See attachment	2,029		See attachment	96	2
3	6	Maintenance	See attachment	See attachment	See attachment	10,713		See attachment	260	3
4	7	Waste Removal	See attachment	See attachment	See attachment	6		See attachment	0	4
5	10	Nursing & Medical Records	See attachment	See attachment	See attachment	0		See attachment	0	5
6	10a	Therapy	See attachment	See attachment	See attachment	452		See attachment	11	6
7	19	Professional Services	See attachment	See attachment	See attachment	7,709,475		See attachment	195,691	7
8	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	See attachment	17,834		See attachment	721	8
9	21	Clerical & General Office Expens	See attachment	See attachment	See attachment	2,749,973		See attachment	68,640	9
10	22	Employee Benefits & Payroll Taxe	See attachment	See attachment	See attachment	508		See attachment	12	10
11	24	Travel and Seminar	See attachment	See attachment	See attachment	837,931		See attachment	7,868	11
12	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	See attachment	1,271,868		See attachment	82,102	12
13	32	Interest	See attachment	See attachment	See attachment	53,649		See attachment	3,490	13
14	33	Real Estate Taxes	See attachment	See attachment	See attachment	4,962		See attachment	122	14
15	34	Rent-Facility & Grounds	See attachment	See attachment	See attachment	162,698		See attachment	3,991	15
16	35	Rent-Equipment & Vehicles	See attachment	See attachment	See attachment	31,048		See attachment	758	16
17	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	See attachment	1,962,703		See attachment	48,144	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 14,815,849	$		$ 411,906	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	GMAC Comm Mort Corp		X	Acquisition	$16,717.00	02/06/98	$ 2,411,646	$ 2,370,876	02/01/08	0.0681	$ 172,539	1
2	Complete Care Services		X	Acquisition	$622.00	02/06/98	106,710	112,627	02/06/08	N/A - None	N/A - None	2
3	Manager Note		X	Acquisition	$622.00	02/06/98	106,710	112,627	02/06/08	N/A - None	N/A - None	3
4	Bank of New York		X	Acquisition	$26,193.27	05/01/79	2,172,740		05/01/10	0.0825	166,732	4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	None	02/06/98	Various	637,299	Demand	Prime + 2%	62,013	6
7	Other Interest										31,992	7
8												8
9	TOTAL Facility Related				$44,154.27		$ 4,797,806	$ 3,233,429			$ 433,276	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,797,806	$ 3,233,429			$ 433,276	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	41,549	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	41,549	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	54,818	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	54,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	54,312	8
	1997	52,236	9
	1998	52,999	10
	1999	53,467	11
	2000	41,549	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKWOOD HEALTH CARE CENTER COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0043711

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 208-2740 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		See Attached	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,875 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	362,419	1998	$ 35,152	1
2					2
3	TOTALS	362,419		$ 35,152	3

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$	-	$	$	$	4
5							-				5
6							-				6
7							-				7
8							-				8
	Improvement Type**										
9	leasehold improvements (purchase price)			1998	228,513	19,043	12	19,043		73,451	9
10	leased building (purchase price)			1998	1,998,252	166,521	12	166,521		642,295	10
11	land improvement			1998	14,668	733	20	733		3,585	11
12	flag pole			1998	667	67	10	67		150	12
13	landscaping			1998	1,248	83	15	83		394	13
14	resurface parking lot			1998	35,386	4,423	8	4,423		14,375	14
15	hot water tank			1998	1,975	198	10	198		774	15
16	boiler repair			1998	1,307	109	12	109		406	16
17	roof vent			1998	937	85	11	85		288	17
18	100 series tackboards			1998	1,870	170	11	170		575	18
19	U-2 sound divider			1998	3,768	377	10	377		1,319	19
20	interior door closer			1998	694	63	11	63		206	20
21	new doors			1998	6,565	597	11	597		1,910	21
22	repair fire wall bath			1998	6,059	551	11	551		1,763	22
23	repair fire wall			1998	2,100	191	11	191		680	23
24	install sink disposal			1998	2,672	223	12	223		1,425	24
25	B series reverse osmosis system			1998	4,412	882	5	882		1,875	25
26	paint remodel therapy room			1998	191	19	10	19		102	26
27	signage			1998	464	93	5	93		213	27
28	track 12x8 w/90 degree bend			1998	64	6	10	6		18	28
29	sign posts, outside signs			1998	745	68	11	68		242	29
30	panic bars & extension rods			1998	1,300	130	10	130		367	30
31	borders therapy rm remodel			1998	249	23	11	23		68	31
32	remodel therapy room			1999	5,105	464	11	464		1,116	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	drapery	1999	$ 150	$ 15	10	$ 15	$	$ 43	37
38	wall mural	1999	500	100	5	100		283	38
39	office carpets	1999	1,481	296	5	296		839	39
40	carpets	1999	1,481	296	5	296		814	40
41	carpets	1999	1,106	221	5	221		534	41
42	covebase for carpet installation	1999	230	46	5	46		111	42
43	vinyl floor	1999	280	28	10	28		68	43
44	door alarm	1999	639	64	10	64		176	44
45	door alarm	1999	7,516	752	10	752		2,067	45
46	wallpaper	1999	976	195	5	195		472	46
47	wallpaper	1999	632	126	5	126		305	47
48	door alarm	1999	4,475	448	10	448		933	48
49	door alarm	1999	203	20	10	20		42	49
50	plumbing repair	1999	647	32	20	32		72	50
51	refridgerator	1999	486	49	10	49		106	51
52	cabinets	1999	8,668	578	15	578		1,252	52
53	building improvements - CK	2000	4,801	320	15	320		427	53
54	building improvements - INV	2000	806	54	15	54		72	54
55	wallpaper & border	2000	1,435	287	5	287		478	55
56	wallpaper & border	2000	764	153	5	153		229	56
57	install AOS 400 gallon storage tank	2000	5,985	855	7	855		1,354	57
58	boiler repairs	2000	1,657	237	7	237		521	58
59	install Tjerlund motor and wheel on power unit	2000	1,119	160	7	160		400	59
60					-				60
61					-				61
62					-				62
63	(DON'T ENTER BELOW THIS LINE)				-				63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,365,248	$ 200,451		$ 200,451	$	$ 759,195	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 252,454	$ 34,955	$ 34,955	$	Various	$ 130,303	71
72	Current Year Purchases	10,492	867	867		Various	867	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 262,946	$ 35,822	$ 35,822	$		$ 131,170	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			-	$	$	$	$		$	76
77			-							77
78			-							78
79			-							79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,663,346	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 236,273	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 236,273	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 890,365	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 19,510 Description: Central Supply - 10,478, Dietary - 2,284, Plant - 2,213, Housekeeping - 38, Laundry - 242, Administrative - 3,98
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. **HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?**
   [ ] YES
   [X] NO
   Training was not necessary for aides, as the facility only hired aides who were already trained.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. **CLASSROOM PORTION:**
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. **CLINICAL PORTION:**
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	1,707	$ 105,747	$ 5,417	1,707	$ 111,164	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		143	17,384	-	143	17,384	2
3	Licensed Recreational Therapist	10a, 3	hrs		-	-	46,493		46,493	3
4	Physical Therapist	10a, 3	hrs		2,197	183,744	3,983	2,197	187,727	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts		-	-	-			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	4,047	$ 306,875	$ 55,893	4,047	$ 362,768	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 54,861	$	1
2	Cash-Patient Deposits	201,280		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	702,142		3
4	Supply Inventory (priced at)	7,756		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 966,039	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,152		13
14	Buildings, at Historical Cost	2,356,584		14
15	Leasehold Improvements, at Historical Cost	51,968		15
16	Equipment, at Historical Cost	262,946		16
17	Accumulated Depreciation (book methods)	(890,365)		17
18	Deferred Charges	1,671,182		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Rec / (Pay)	(1,715,782)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,771,685	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,737,724	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 433,922	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,981		28
29	Short-Term Notes Payable	314,877		29
30	Accrued Salaries Payable	228,538		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	5,747		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,006,065	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,545,135		39
40	Mortgage Payable	1,696,666		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,241,801	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,247,866	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,510,142)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,737,724	$	48

***(See instructions.)**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,677,773)	1	
2	Restatements (describe):		2	
3	**Restatements of Prior Year to allow rollforward**	245,634	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,432,139)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,078,003)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,078,003)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,510,142)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,693,607	1
2	Discounts and Allowances for all Levels	(448,422)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,245,185	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	453,764	6
7	Oxygen	68,910	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 522,674	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	463	13
14	Non-Patient Meals	1,474	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,070	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,411	19
20	Radiology and X-Ray		20
21	Other Medical Services	46,239	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 162,657	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,930,516	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	910,054	31
32	Health Care	1,778,930	32
33	General Administration	1,229,428	33
	B. Capital Expense		
34	Ownership	887,188	34
	C. Ancillary Expense		
35	Special Cost Centers	65,819	35
36	Provider Participation Fee	137,100	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,008,519	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,078,003)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,078,003)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,549	2,790	$ 71,181	$ 25.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,193	15,916	269,096	16.91	3
4	Licensed Practical Nurses	30,838	32,258	381,122	11.81	4
5	Nurse Aides & Orderlies	44,071	47,314	404,690	8.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	605	605	8,424	13.92	8
9	Activity Director	1,716	1,806	16,875	9.34	9
10	Activity Assistants	3,516	3,566	28,703	8.05	10
11	Social Service Workers	4,243	4,594	51,718	11.26	11
12	Dietician	6,802	6,802	49,030	7.21	12
13	Food Service Supervisor	1,403	1,451	17,921	12.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,558	15,616	101,703	6.51	15
16	Dishwashers					16
17	Maintenance Workers	6,817	7,005	60,093	8.58	17
18	Housekeepers	10,821	11,514	81,931	7.12	18
19	Laundry	7,473	7,888	79,473	10.08	19
20	Administrator	3,749	3,813	76,164	19.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,207	7,682	119,313	15.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	935	935	18,704	20.00	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,922	3,021	36,225	11.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,418	174,576	$ 1,872,366 *	$ 10.73	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	226	$ 9,102	1, 3	35
36	Medical Director				36
37	Medical Records Consultant	11	275	10, 3	37
38	Nurse Consultant	48	12,000	10, 3	38
39	Pharmacist Consultant	96	600	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	48	2,609	12, 3	45
46	Other(specify)				46
47	0	210	10,492	0	47
48					48
49	TOTAL (lines 35 - 48)	639	$ 35,078		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	615	$ 21,526	10, 3	50
51	Licensed Practical Nurses	69	1,721	10, 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	684	$ 23,247		53

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Newell & Pat Thieben	Admin.	0%	$ 76,164
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,164

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 8,019
Patient Litigation	Various	110,367
Payroll Processing	Various	13,310
Accounting	Various	100
EDP Services	Various	4,234
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 136,030

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,020
Unemployment Compensation Insurance	-
FICA Taxes	172,971
Employee Health Insurance	122,946
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	-
	-
	-
Home Office Allocation	12
TOTAL (agree to Schedule V, line 22, col.8)	$ 347,949

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,154
Health Care Worker Background Check	
(Indicate # of checks performed 46)	
Dues & Subscriptions	1,004
Advertising & Public Relations	(1,532)
Home Office Allocation	721
Less: Public Relations Expense	
Non-allowable advertising	#VALUE!
Yellow page advertising	#VALUE!
TOTAL (agree to Sch. V, line 20, col. 8)	$ #VALUE!

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	14,182
Seminar Expense	589
Business Meals	25
Home Office Allocation	7,868
Less: Entertainment Expense	#VALUE!
TOTAL (agree to Sch. V, line 24, col. 8)	$ #VALUE!

**See instructions.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **24,316** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **137,100**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **1,474**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.